MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

★ 1 04213

Reg. Diat. No. 350

1. PLACE OF DEATH:
County: Worcester
City or town: Pocomoke Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 years
Hospital, Institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Maryland County: Worcester
City or town: Pocomoke Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Walnut Street
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Mark Stevens Brooks

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Unknown
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): March 22, 1863

8. AGE: Years	Months	Days	If less than one day
83	0	29	...hrs. ...min.

9. Birthplace: Cornell N.Y. (Town, county, and state)
10. Usual occupation: Retired ex Dept farmer
11. Industry or business: Farm
FATHER 12. Name: Unknown
13. Birthplace: "
MOTHER 14. Maiden name: Unknown
15. Birthplace: "
16. Informant: Mr Daniel W. Shaw Jr.
Address: Pocomoke Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 24 1946 (month) (day) (year)
Cemetery or crematory: Hope Cemetery
Location: Hartsell N.J.
18. Funeral director: Henry L. Watson
Address: Pocomoke Md.
19. April 22 1946 (Date rec'd by registrar) Anne E. White Registrar

MEDICAL CERTIFICATION

A.M.

20. DATE OF DEATH: April 21st., 1946, at 5:20 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 20th., 1946, to 4/21/46., 19...
and that I last saw him alive on April 20th., 1946

Immediate cause of death	DURATION
Cardiac failure.	
Due to: Coronary occlusion.	Few hours.
Due to: Coronary sclerosis.	(?)
Other conditions: Acute pulmonary congestion (Include pregnancy within 3 months of death)	Few hours

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: R. Lee Hall M. D. or other
Address: Pocomoke City, Md. Date signed: 4/21/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

CERTIFICATE OF DEATH

Reg. Dist. No. 04214353

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Worcester

City or town: Bishop Md. Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 41 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Worcester

City or town: Bishop Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Eva Katie Bunting

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	(John) married

6.(b) Name of husband or wife: John R. Bunting

6.(c) If alive, give age: 76 years

7. Birth date of deceased (mo., day, yr.): 1872

8. AGE:

Years	Months	Days	If less than one day
74			....hrs. ....min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER

12. Name: George Baker

13. Birthplace:

MOTHER

14. Maiden name: Ella Holloway

15. Birthplace:

16. Informant: John R. Bunting

Address: Bishop, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof apr. 14 1946 (month) (day) (year)

Cemetery or crematory: Red Men's Cem

Location: Delmar Del.

18. Funeral director: Margarette A. Watson

Address: Pocomoke City, Md.

19. Apr. 13 1946 (Date rec'd by registrar) A. W. Hedrick. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 11 1946, at 6:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1 1946 to Apr. 10 1946

and that I last saw h[illegible] alive on April 10 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	11 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: G E James M. D. or other

Address: Delmar, Del. Date signed 4-13-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

04215

Reg. Dist. No. 351

WITHIN CORPORATE LIMITS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Worcester
City or town Snow Hill
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Worcester
City or town Snow Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war None

3. (a) FULL NAME Maggie Collick

3. (b) Social Security Number None

4. Sex: Female
5. Color or race: Colored
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: James Collick
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): 1854
8. AGE: Years 92 | Months | Days | If less than one day ..... hrs. ..... min.
9. Birthplace: Snow Hill Worcester Md (Town, county, and state)
10. Usual occupation: None
11. Industry or business: —
12. FATHER — Name: Unknown
13. FATHER — Birthplace: "
14. MOTHER — Maiden name: Unknown
15. MOTHER — Birthplace: "
16. Informant: Worcester County Welfare Board
Address: Snow Hill, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof April 27 46 (month) (day) (year)
Cemetery or crematory: M.E. Wesley
Location: Snow Hill, Md
18. Funeral director: Pearre & Dennis
Address: Snow Hill, Md
19. 4/27 1946 (Date rec'd by registrar) R. LeRoy Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25 19 46, at 7 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 16 1945 to April 25 1946 and that I last saw h.er alive on April 25 1946

Immediate cause of death	DURATION
Congestive Cardiac failure	2 wks
Due to: Cardiovascular Hypertension Renal Syndrome	10 yrs
Due to:	
Other conditions: Rectal Hemorrhages	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE Robert L. LeMar M.D. M. D., or other
Address Snow Hill Date signed 4/26/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (108)

04217

CERTIFICATE OF DEATH

Reg. Diat. No. 355

1. PLACE OF DEATH:
County: Worcester
City or town: Whaleyville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Whaleyville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Lettie Ellen Carey

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Thomas Carey
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb 27 1876

8. AGE: Years	Months	Days	If less than one day
70	2	3	hrs. min.

9. Birthplace: Worcester Co. Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: John Henry Hudson
13. Birthplace: Unknown
MOTHER 14. Maiden name: Unknown
15. Birthplace
16. Informant: Robert Carey
Address: Grand Hotel, South River
17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-3-1946 (month) (day) (year)
Cemetery or crematory: Whaleyville Cemetery
Location: Whaleyville, Md
18. Funeral director: Mrs. M. Pasha Watson
Address: Selbyville Del.
19. May 2 1946 (Date rec'd by registrar) Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-30- 1946 at 2.10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-18- 1946 to 4-30- 1946 and that I last saw h- alive on 4-30 1946

Immediate cause of death	DURATION
Labor	
Due to: Pneumonia	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Chas. R. Law M. D. or other
Address: Berlin Md Date signed 5-2-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04216

CERTIFICATE OF DEATH

Reg. Dist. No. 351

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9145

1. PLACE OF DEATH: Volcanter
County Wicomico
City or town Whiton (near)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. Delmar Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Benjamin Thomas Davis
3.(b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widower
6.(b) Name of husband or wife: Anna Kate Davis
6.(c) If alive, give age: Dead years
7. Birth date of deceased (mo., day, yr.): Dec. 14-1859
8. AGE: Years 86 Months 3 Days 19 If less than one day ..... hrs. ..... min.
9. Birthplace: Whiton Md. (Town, county, and state)
10. Usual occupation: Retired Farmer
11. Industry or business:
FATHER 12. Name: Silas Davis
13. Birthplace: Whiton Md.
MOTHER 14. Maiden name: Sallie Jones
15. Birthplace: Whiton Md.
16. Informant: Mrs. Jennie Collins
Address: Delmar Road, Salisbury Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 8 46 (month) (day) (year)
Cemetery or crematory: St. Johns Cem.
Location: Near Powellville Md.
18. Funeral director: Holloway & G. Walter R. Holloway
Address: Salisbury Maryland
19. 4/8/46 (Date rec'd by registrar) R. Roy Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3rd 1946, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Coronary Occlusion	months
Due to: Generalized Arteriosclerosis	30 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Nature of injury: ..... Injured at work?

23. SIGNATURE: L. S. Scott M.D.
M. D. or other
Address: Berlin Md. Date signed: 4/8/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (168)

04218

CERTIFICATE OF DEATH

Reg. Diat. No. 350

1. PLACE OF DEATH

County Worcester

City or town Rural Pocomoke Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs

Hospital, Institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Worcester

City or town Pocomoke Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Emma Frances Davis

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Married

6.(b) Name of husband or wife Thomas Davis

6.(c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) May 30, 1894

8. AGE: Years	Months	Days	If less than one day
51	10	17	...hrs. ...min.

9. Birthplace Godwill, Worcester Md. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Isaac Merritt

13. Birthplace Md

MOTHER 14. Maiden name Elizabeth Ward

15. Birthplace Md.

16. Informant Mrs Pauline Bromley

Address Salisbury Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 19-1946 (month) (day) (year)

Cemetery or crematory Hollis Hill Baptist Cem.

Location Pocomoke Md.

18. Funeral director Henry H. Watson

Address Pocomoke Md.

19. April 20 1946 (Date rec'd by registrar) Anne E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/16th 1946, at D.K. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 15th, to dead 19...

and that I last saw h...alive on ...19...

Immediate cause of death	DURATION
Strangulation	
Due to Probable Homicide	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ...

...Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide? Probable Homicide Date of 4/16/46

Where did injury occur? Pocomoke (City or town) Worcester (County) Md (State)

Injured at home, farm, industry, public place (where?) In home entrance Garage

Means of injury Strangulation Injured at work? No

23. SIGNATURE N. E. Antonios M.D. M. D. or other

Address Pocomoke City Md Date signed 4/18/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04219

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH:
County: Worcester
City or town: Pocomoke
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 days
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Worcester
City or town: Berlin
(If outside city or town limits, write RURAL and give nearest town)
Street No. 116 North Main
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Mary Ellen Gumby

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Chester M. Gumby
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): October 9, 1877

8. AGE: Years 68 | Months 6 | Days 5 | If less than one day ____ hrs. ____ min.

8. Birthplace: Whaleyville Worcester County Md
(Town, county, and state)

10. Usual occupation: House wife

11. Industry or business

FATHER
12. Name: John Powell
13. Birthplace: Worcester County

MOTHER
14. Maiden name: Hettie M. Williams
15. Birthplace: Worcester County

16. Informant: Mrs Paul Ewell
Address: Pocomoke City, Md

17. (Burial, cremation, or removal. Which?) Burial Date thereof (month) (day) (year) April 16 1946
Cemetery or crematory: Buckingham Cemetery
Location: Berlin, Maryland

18. Funeral director: H. Harlan Beadshaw
Address: Pocomoke City, Md

19. (Date rec'd by registrar) April 16 1946 Anne E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 14th, 1946 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 10th, 1946 to 4/14/46. 19____
and that I last saw her alive on April 14th, 1946. 19____

Immediate cause of death	DURATION
Exhaustion.	
Due to Cerebral hemorrhage.,	4 days
Due to Hypertension and arterio sclerosis.	Years
Other conditions None.	

(Include pregnancy within 3 months of death)

Major findings of operation:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: R. Lee Hall M. D. or other
Address: Pocomoke City, Md. Date signed: 4-16-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

04220

CERTIFICATE OF DEATH

Reg. Dist. No. 351

1. PLACE OF DEATH:

County: Worcester

City or town: (or Snow Hill) (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred: no

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Worcester

City or town: Snow Hill md (If outside city or town limits, write RURAL and give nearest town)

Street No. no R.F.D. No 2 (If rural, give LOCATION)

2.(a) If veteran, name war: no

3. (a) FULL NAME: Georgiana James

3. (b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	a.a.	Married

6.(b) Name of husband or wife: Lewis James

6.(c) If alive, give age: Yes years

7. Birth date of deceased (mo., day, yr.): about 1878

8. AGE: Years	Months	Days	If less than one day
about 67			hrs. min.

9. Birthplace: Snow Hill md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Same as above

FATHER 12. Name: Benjamin Hammond

FATHER 13. Birthplace: Snow Hill md

MOTHER 14. Maiden name: Emeline Hammond

MOTHER 15. Birthplace: Snow Hill md

16. Informant: Rev Lewis James

Address: Snow Hill md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 16 1946 (month) (day) (year)

Cemetery or crematory: Ebenezer

Location: Snow Hill

18. Funeral director: James P. Stewart

Address: Salisbury Md

19. 4/16 1946 (Date rec'd by registrar) LeRoy Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4/13/46 19..., at 1:15 A.M.

21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from Jan 1945 19... to April 12 1946

and that I last saw her alive on 4/12/46 19...

Immediate cause of death: Coronary Thrombosis — DURATION: 1 day

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Paul Cohen M.D. M. D. or other

Address: Snow Hill Md Date signed: 4/16/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (930)

CERTIFICATE OF DEATH

★ 04221 955 Reg. Dist. No.

1. PLACE OF DEATH:
County: Worcester
City or town: ~~Ocean City~~ Bishopville Bishop
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 34 yrs.
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Bishop, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.F.D.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: James King

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Sallie M. King
6.(c) If alive, give age: 84 years

7. Birth date of deceased (mo., day, yr.): Sept 15 1865

8. AGE: Years	Months	Days	If less than one day
80	7	5	...hrs. ...min.

9. Birthplace: Maryland.
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Farming
12. Name of FATHER: ~~John~~ King
13. Birthplace: Md.
MOTHER
14. Maiden name: Sallie (Unknown)
15. Birthplace: Md.
16. Informant: Sallie M. King
Address: Bishop Md. R.F.D.
17. Burial (Burial, cremation, or removal. Which?) Date thereof April 23 1946 (month) (day) (year)
Cemetery or crematory: Evergreen
Location: Berlin, Md.
18. Funeral director: M. Pasha Watson
Address: Selbyville Del.
19. 4-21 1946 (Date rec'd by registrar) Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 20 1946 at 5:25 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 4/19 1946 to 4/20 1946
and that I last saw h...m alive on 20th April 1946

Immediate cause of death	DURATION
Uremia	
Due to: Arterio Sclerotic Heart Disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: W Garrett Hume M.D.
M. D. or other
Address: Selbyville, Del. Date signed: 4-21-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94)

CERTIFICATE OF DEATH

04222

Reg. Dist. No. 350

1. PLACE OF DEATH:
County Worcester
City or town (Unionville) Pocomoke R.3.D.2. Bx.30
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? about 30 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? ~

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Worcester
City or town (Unionville) Pocomoke R.F.D. 2 Bx 30.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Harrison Knox

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Married

6.(b) Name of husband or wife Tobitha Brittingham Knox. 6.(c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) September ? 1893

8. AGE: Years 52 | Months 7 | Days | If less than one day ... hrs. ... min.

9. Birthplace Middletown, Va (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Farming.

FATHER
12. Name Henry Knox
13. Birthplace Acco. Co. Va

MOTHER
14. Maiden name Eliza Lawson.
15. Birthplace Accomac Co., Va

16. Informant Eliza Knox
Address Pocomoke, Md. R.F.D. 2 Bx 30

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 17, 1946. (month) (day) (year)

Cemetery or crematory Unionville M. Cemetery.
Location Unionville, Md.

19. Funeral director J. Edgar Thomas.
Address Accomac, Virginia.

19. April 16 1946 (Date rec'd by registrar) Anne E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14th 1946, at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 14th, 46 to April 14th, 46 and that I last saw him alive on April 14th, 1946.

Immediate cause of death	DURATION
Cardiac failure,	
Due to Coronary occlusion,	few hours
Due to Arterio-sclerosis,	(?)
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE R. Lee Hall M. D. or other
Address Pocomoke City, Md. Date signed 4/15/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 85-0

CERTIFICATE OF DEATH

Reg. Dist. No. 11422 353

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Worcester
City or town: Selbyville Del (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Worcester
City or town: Selbyville Del. Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Amanda Martin

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colard	Married

6.(b) Name of husband or wife: Ernest Martin
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): 1882

8. AGE: Years: 64 | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: Md.
(Town, county, and state)
10. Usual occupation: Cook
11. Industry or business:
12. Name of FATHER: Joshua Ward
13. Birthplace of FATHER: Md.
14. Maiden name of MOTHER: Maria Robbins
15. Birthplace of MOTHER: Md.
16. Informant: Bertie Harmon
Address: Selbyville, Del.
17. (Burial, cremation, or removal. Which?) Burial Date thereof 4-11-46 (month) (day) (year)
Cemetery or crematory: Coolspring
Location: near Fiddletown Md.
18. Funeral director: Marquette A. Walson
Address: Pocomoke City, Md.
19. (Date rec'd by registrar) 4/11/46 Registrar: Mrs Ray Berger

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr. 7 1946, at 2 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 25 1946 to April 6th 1946 and that I last saw her alive on about 6th 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	12 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: G E James M. D. or other
Address: Selbyville, Del. Date signed 4-9-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (124)

04224

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH:

County Worcester

City or town Ocean City

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, institution, or street address where death occurred

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Worcester

City or town Ocean City

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME George Edward McLaine.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Maggie McLaine

6.(c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) Jan. 2, 1888.

8. AGE:

Years	Months	Days	If less than one day
58	3	20	...hrs. ...min.

9. Birthplace Wilmington Delaware
(Town, county, and state)

10. Usual occupation Fisherman

11. Industry or business

FATHER 12. Name Samuel McLaine.

13. Birthplace Delaware.

MOTHER 14. Maiden name Katherine Doyle

15. Birthplace Germany

16. Informant Mrs. George McLaine

Address Ocean City, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/25/46 (month) (day) (year)

Cemetery or crematory Taylorville

Location Berlin Md R.F.D.

18. Funeral director Anna A. Burbage

Address Berlin Md.

19. 4-25 1946 (Date rec'd by registrar) Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22nd 1946, at 11:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1st 1946, to April 22 1946, and that I last saw h... alive on April 22 1946.

Immediate cause of death	DURATION
Chronic Myocarditis	6 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. Stovall M.D.
M. D. or other

Address Berlin Md Date signed 4/25/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 956

04225

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH:
County Worcester
City or town Berlin
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 27 years.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Worcester.
City or town Berlin.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Jewell James Nock.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single.

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 27, 1918

8. AGE:

Years	Months	Days	If less than one day
27	9	12	..... hrs. ..... min.

9. Birthplace Berlin Wor Co. Md.
(Town, county, and state)
10. Usual occupation None
11. Industry or business
FATHER 12. Name Gordon Nock.
13. Birthplace Berlin Md.
MOTHER 14. Maiden name Rosina McCabe.
15. Birthplace Berlin Md.
16. Informant Mrs. Gordon Nock
Address Berlin Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/11/46 (month) (day) (year)
Cemetery or crematory Evergreen.
Location Berlin Md.
18. Funeral director Anna B. Burbage
Address Berlin Md.
19. 4-11 1946 (Date rec'd by registrar) Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1946 at 10 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1938 to April 8 1946
and that I last saw h[illegible] alive on April 7 1946
Immediate cause of death Pulmonary Heart Disease — DURATION 20 yrs
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [signature] M. D.
M. D. or other
Address Berlin Md. Date signed 4/10/46

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-2)

CERTIFICATE OF DEATH

(*) 04226 Reg. Dist. No. 350

1. PLACE OF DEATH:
County Worcester
City or town Pocomoke city, md Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 months
Hospital, institution, or street address where death occurred: ✓
How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Worcester
City or town Pocomoke city Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. ✓
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME Annie Elizabeth Pennewell

3. (b) Social Security Number ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Widowed

6.(b) Name of husband or wife Jed Pennewell
6.(c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) July 4, 1850

8. AGE: Years 95 Months 8 Days 28 If less than one day ..... hrs. ..... min.

9. Birthplace Stockton, Worcester, md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Thomas Smack
13. Birthplace md.

MOTHER
14. Maiden name Catherine Pruitt
15. Birthplace md.

16. Informant Grover Pennewell
Address Franklin city, md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 4, 1946 (month) (day) (year)
Cemetery or crematory Greenbrook
Location Greenbrookville, Va

18. Funeral director Margarette N. Watson
Address Pocomoke city, md

19. April 5 1946 (Date rec'd by registrar) And E White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1946, at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ~~1945~~ July 7 to August 7 1946
and that I last saw her alive on August 5 1946

	DURATION
Immediate cause of death Pneumonia, Hypostatic	3 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE J. E. Cathey M. D. or other
Address Pocomoke city, md Date signed April 4 1946

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21-E)

CERTIFICATE OF DEATH

04227

Reg. Dist. No. 350

1. PLACE OF DEATH:
County Worcester
City or town Pocomoke City Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 46 years
Hospital, institution, or street address where death occurred:
—
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State Maryland County Worcester
City or town Pocomoke City Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME John William Reid

3. (b) Social Security Number —

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife: Katherine Reid
6.(c) If alive, give age: 60 years
7. Birth date of deceased (mo., day, yr.): Sept 14, 1881
8. AGE: Years: 64 Months: 7 Days: 4 If less than one day: hrs. min.
9. Birthplace: Stockton Worcester Md.
(Town, county, and state)
10. Usual occupation: Merchant
11. Industry or business: —

FATHER
12. Name: John W. Reid
13. Birthplace: Md

MOTHER
14. Maiden name: Elizabeth Lambertson
15. Birthplace: Md

16. Informant: Mrs Katherine Reid
Address: Pocomoke City Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 21 1946 (month) (day) (year)
Cemetery or crematory: Bethany M.P. Cemetery
Location: Pocomoke City Md.

18. Funeral director: Henry A. Watson
Address: Pocomoke City Md.

19. April 20 19 46 Anne E. White
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18th, 1946, at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from From time to time 19 about 4 years. 19
and that I last saw him alive on April 16th, 1946. 19

	DURATION
Immediate cause of death: Heart failure.	
Fell over dead while at dinner.	
Due to: Myocarditis.	
Chronic nephritis.	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE R Lee Hall M. D. or other
Address Pocomoke City, Md. Date signed 4/20/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

04228

CERTIFICATE OF DEATH

Reg. Dist. No. 357

WITHIN CORPORATE LIMITS OF

1. PLACE OF DEATH:
County Worcester
City or town Snow Hill
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 85 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Worcester
City or town Snow Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME Charles W. Shackley

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Georgiana Shackley
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 20 1861

8. AGE: Years 85 | Months | Days 2 | If less than one day ..... hrs. ..... min.

9. Birthplace Snow Hill Worcester Md (Town, county, and state)

10. Usual occupation Merchant

11. Industry or business Town Store

FATHER 12. Name Lorenzo D. Shackley
13. Birthplace Maryland

MOTHER 14. Maiden name Jane Elizabeth Shackley
15. Birthplace Maryland

16. Informant Miss Evelyn Shackley
Address Snow Hill, Md

17. Burial Date thereof April 24 46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Bates
Location Snow Hill, Md

18. Funeral director Adams & Timmons
Address Snow Hill, Md

19. 4/24 1946 R. Ray Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 1946, at 7 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 18 1943, to April 22 1946, and that I last saw him alive on April 21 1946.

	DURATION
Immediate cause of death: Acute Pulmonary Edema	2 days
Due to: Hypertensive Cardiovascular Renal disease	5 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE Robert L. LeMar, M.D.
M. D. or other
Address Snow Hill Date signed 4/23/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

114229

Reg. Dist. No. 350

1. PLACE OF DEATH.
County Worcester
City or town Pocomoke
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Worcester
City or town Pocomoke
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Sallie M. Sturgis

3.(b) Social Security Number —

4. Sex Female

5. Color or race Colored

6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Silas Sturgis

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Unknown 1877

8. AGE: Years 69 | Months — | Days — | If less than one day ... hrs. ... min.

9. Birthplace Pocomoke Worcester Md
(Town, county, and state)

10. Usual occupation housewife

11. Industry or business —

12. FATHER Name Frank Bratten

13. FATHER Birthplace Md

14. MOTHER Maiden name Emma Armstrong

15. MOTHER Birthplace Md

16. Informant Silas Sturgis
Address Pocomoke Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 26 1946 (month) (day) (year)
Cemetery or crematory Hall's Hill
Location Rural Pocomoke Md.

18. Funeral director Henry L. Watson
Address Pocomoke Md.

19. April 26 1946 (Date rec'd by registrar) Anna E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1946, at 29 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Due to Starvation	Several weeks
Due to Insanity	3 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ...
Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE N. E. Antonio M.D.
M. D. or other
Address Pocomoke City Md Date signed 4/25/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

04230

Reg. Dist. No. 351

1. PLACE OF DEATH:
County: Wicomico
City or town: Snow Hill Rural #
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Snow Hill Rural #
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: 70

3. (a) FULL NAME: Hattie Taylor

3. (b) Social Security Number: None

4. Sex: Female
5. Color or race: Colored
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Thomas Taylor
6.(c) If alive, give age: 60 years
7. Birth date of deceased (mo., day, yr.): July 5 - 1895
8. AGE: Years: 50 Months: 9 Days: 21 If less than one day: hrs. min.
9. Birthplace: Plymouth (Town, county, and state) North Carolina
10. Usual occupation: Home wife
11. Industry or business: own Home

FATHER
12. Name: Unknown
13. Birthplace: "

MOTHER
14. Maiden name: Unknown
15. Birthplace: "

16. Informant: Thomas Taylor
Address: Snow Hill, Md Rural #

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 29 46 (month) (day) (year)
Cemetery or crematory: Baptist
Location: Snow Hill, Md

18. Funeral director: Deame & Dennis
Address: Snow Hill, Md

19. 4/27 1946 (Date rec'd by registrar) R. Ray Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 26 1946 at 4 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1945, to April 26 1946 and that I last saw h.er alive on April 20 1946

	DURATION
Immediate cause of death: Coronary Thrombosis	1 day
Due to: Arteriosclerotic Hypertensive Heart disease	unknown
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Paul Cohen M. D.
M. D. or other
Address: Snow Hill Date signed: 4/26/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (830)

CERTIFICATE OF DEATH

014231

Reg. Dist. No. 955

1. PLACE OF DEATH:

County: Worcester

City or town: Berlin Md (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred: no

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Worcester

City or town: Berlin Md (If outside city or town limits, write RURAL and give nearest town)

Street No.: no (If rural, give LOCATION)

2.(a) If veteran, name war: no

3. (a) FULL NAME: Charles Timmons

3. (b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	a.a.	Widower

6.(b) Name of husband or wife: Elezebeth Timmons

Dead 6.(c) If alive, give age: no years

7. Birth date of deceased (mo., day, yr.): about 1868

8. AGE:

Years	Months	Days	If less than one day
78	—	—	hrs. 3 min.

9. Birthplace: Berlin md (Town, county, and state)

10. Usual occupation: Sheff

11. Industry or business: Same as above

FATHER 12. Name: Eyyus Timmons

FATHER 13. Birthplace: Berlin md

MOTHER 14. Maiden name: Unknown

MOTHER 15. Birthplace: Unknown

16. Informant: Raymond Brodell

Address: Berlin md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 14 1946 (month) (day) (year)

Cemetery or crematory: Evergreen

Location: Berlin Md

18. Funeral director: James H. Stewart

Address: Berlin md

19. 4-14 1946 (Date rec'd by registrar) Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 11 1946, at 4:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Cerebral	
Due to: Hemorrhage	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Chas. R. Lair MD (M. D. or other)

Address: Berlin Md. Date signed 4-13-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
APR 18 1946
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH:
County: Worcester
City or town: Ocean City md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years
Hospital, Institution, or street address where death occurred: no
How long in hospital or Institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Worcester
City or town Ocean City md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 785 Wildmica
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME Frederick Frye

3.(b) Social Security Number Lost

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	a.a.	Married

6.(b) Name of husband or wife: Dont know
Dont know 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): about 1907

8. AGE: Years	Months	Days	If less than one day
about 39	—	—	..... hrs. ..... min.

9. Birthplace: N. C. Enfield (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Same as above

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: unknown

16. Informant: Mrs Mary Robens
Address: Ocean City md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr (month) 12 (day) 46 (year)
Cemetery or crematory: Evergreen
Location: Berlin Md
18. Funeral director: James H. Stewart
Address: Salisbury md

19. 4-12 (Date rec'd by registrar) 1946 Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4-6 1946 at 10A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-7 1946 to 4-6 1946
and that I last saw h... alive on 4-3 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	7
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Clifford E. Schatt M. D. or other
Address: Berlin Md Date signed 4/8/46

VS A15

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MARGIN RESERVED FOR BINDING